REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

DEFICIENCIES IN MONITORING AND ENFORCING QUALITY OF CARE TO NURSING HOME PATIENTS

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Office of the Auditor General

REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

275.2

DEFICIENCIES IN MONITORING AND ENFORCING QUALITY OF CARE TO NURSING HOME PATIENTS

Department of Health

OCTOBER 1977

Joint Legislative Audit Committee

OFFICE OF THE AUDITOR GENERAL

California Legislature

October 7, 1977

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's report on deficiencies in the imposition of prompt and effective civil and criminal sanctions against licensed nursing care facilities.

He found that the Department of Health has not developed the procedures necessary to identify possible criminal violators of the law. There are also weaknesses in the legislation concerning the imposition of civil sanctions against repeat violators.

The Auditor General also points out that judicial backlogs of up to one year enable defendant nursing facilities to continue to operate. The Attorney General reports, however, that through additional staff, he has reduced to less than three calendar weeks the time between the referral by the Department of Health and the formal filing of an accusation.

State legal costs often exceed the maximum fine available should the action be adjudicated in the State's favor. Clearly, other means of enforcement of standards should be considered by the legislative policy committees to which this report is referred for review and appropriate action.

By copy of this letter, the Department is requested to advise the Joint Legislative Audit Committee within sixty days of the status of implementation of the recommendations of the Auditor General that are within the statutory authority of the Department.

The auditors are: Harold L. Turner, Manager; Robert E. Christophel; Mildred M. Kiesel, CPA; Dore C. Tanner, CPA; and Kathleen A. Herdell.

Respectfully submitted,

MIKE CULLEN
Chairman

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TABLE OF CONTENTS

SUMMARY

The Joint Legislative Audit Committee requested that we evaluate the Department of Health's performance in monitoring and enforcing the quality of care provided to patients in skilled nursing facilities.

The primary authority for enforcing quality care in skilled nursing facilities is the Long-Term Care, Health, Safety, and Security Act of 1973. A major provision of the Act is a citation system for imposing prompt and effective civil sanctions against facilities which violate the law.

The Department of Health has not developed the procedures necessary to identify possible criminal violators. Further, there are weaknesses in legislation concerning the imposition of civil sanctions against repeat violators and in the enforcement of Class "B" violations in court.

We recommend that the Department of Health maintain a profile or summary of violations of each skilled nursing facility to better detect repeat violations and patterns of noncompliance (see page 18).

We also recommend that the Legislature consider imposing automatic fines against facilities which repeatedly violate the same regulations regardless of whether the original violation has been corrected (see page 18).

The Attorney General and the Department of Health have not promptly prepared accusations to revoke skilled nursing facility licenses nor promptly filed civil complaints to enforce citations and collect penalties. Facilities continuing to operate for excessively long periods pending license revocation action may threaten the health, safety and security of their patients.

We recommend that the Division of Licensing and Certification, the Office of Legal Affairs and the Office of the Attorney General develop the guidelines and procedures necessary to expedite preparation of legal actions against nursing facilities (see page 24).

We also recommend that the Office of the Attorney General and the Department of Health report to the Joint Committee on Aging and the Joint Legislative Audit Committee on the effectiveness and efficiency of their new systems for processing legal actions (see page 24).

Because there is no statewide procedure to control complaint investigations, complaint data cannot be effectively used as a management tool for statewide planning and district control.

We recommend that the Department of Health develop standardized procedures among its district offices for documenting complaints (see page 27).

Implementing each of these recommendations would improve the citation enforcement system which, in turn, would more effectively and efficiently utilize the resources of the State and the skilled nursing industry.

INTRODUCTION

In response to a resolution of the Joint Legislative Audit Committee of the California Legislature, we have evaluated the Department of Health's performance in monitoring and enforcing standards for the quality of care provided to patients in skilled nursing facilities. This review was conducted under the authority vested in the Auditor General by Section 10527 of the Government Code.

This is the second in a series of reports addressing the issue of long-term care for the aged. Report Number 275.1, "Long-Term Care for the Aged (Part One), An Overview and Medi-Cal Reimbursements for Skilled Nursing Care," was released in January 1977.

The Licensing and Certification Division of the Department of Health is responsible for licensing approximately 1,200 California nursing facilities and enforcing the standards of care provided to approximately 106,000 patients in these facilities. Approximately two-thirds of these patients are Medi-Cal recipients. In fiscal year 1975-76, Medi-Cal payments to skilled nursing facilities amounted to over $348 million, representing 15.7 percent of the total Medi-Cal budget of approximately $2.2 billion.

The licensing and certification functions are decentralized and are delegated to eight district offices located throughout California. Facility inspection teams from each district office are mandated by federal and state law to annually make at least two general inspections of nursing homes. Facility inspection teams are composed of a registered nurse and a general inspector. Other specialists, such as physicians, pharmacists, dietitians or social workers assist inspection teams as needed. The team interviews patients, evaluates the physical and psychosocial condition of the patients, reviews medical records and inspects the facility plant in accordance with state and federal survey requirements.

The primary authority for enforcing quality care in skilled nursing facilities is the Long-Term Care, Health, Safety, and Security Act of 1973. The Act provides for:

- An inspection system to ensure that skilled nursing facilities are in compliance with state statutes and regulations

- A citation system for imposing prompt and effective civil sanctions against facilities which are in violation of the law.

This report identifies deficiencies associated with the enforcement of quality care in skilled nursing facilities. We reviewed the enforcement of regulations in several licensing and certification district offices. We also reviewed the related operations of the Office of Legal Affairs of the Department of Health and the Office of the Attorney General. In addition, we developed a computerized system to assist us in our analysis of citations.

While this report addresses significant enforcement problems relating to quality of care in nursing facilities, it should be noted that 714 facilities or approximately 60 percent of all nursing facilities in California, received no significant citations in 1976.

A new deputy director was appointed to the Licensing and Certification Division in July 1977, and this report should assist him in carrying out his responsibilities.

The courtesy and cooperation extended to our auditors by the state agencies and the nursing home industry are appreciated.

SUMMARY OF THE LONG-TERM CARE, HEALTH, SAFETY, AND SECURITY ACT OF 1973

This section describes both the citation enforcement and complaint investigation processes and will aid the reader in understanding the enforcement and complaint investigation issues discussed later in this report.

Citation Enforcement Process

The Division of Licensing and Certification of the Department of Health issues citations when a nursing facility violates any statutory provision, rule or regulation relating to the health, safety or security of patients. The Department classifies violations as "A", "B" or "C", depending upon the severity of the infraction. The following is a discussion of these classifications:

- Class "A" violations--present an imminent danger to the patients of a nursing facility or a substantial probability that death or serious harm would result therefrom. For example, Class "A" violations may occur when patients have not been given the care necessary to prevent the development of decubitus ulcers (bed sores), when an attending physician has not been immediately notified about patients who exhibit unusual signs or behavior, or when a facility has accepted and retained patients for whom it could not provide adequate care. These violations are subject to a civil penalty of not less than $1,000 and not more than $5,000 for each violation.

- Class "B" violations--have a direct or immediate relationship to the health, safety or security of a nursing facility patient. These violations are less critical than Class "A" violations. For example, Class "B" violations may occur when a required therapeutic diet has not been provided to a patient, when medical treatment is not administered as prescribed, or when a facility is not clean, sanitary and in good condition. These violations are subject to a civil penalty of not less than $50 and not more than $250 for each violation. No fine is imposed when Class "B" violations are corrected within the time specified in the citation notice.

- Class "C" violations--relate to the operation and maintenance of a nursing facility and have only a minimal relationship to the health or safety of patients. Fines are not assessed for Class "C" violations.

Sometime after a citation is issued, the facility is reinspected to determine if the violations were corrected within the time specified by the Department. If the facility fails to correct the violation within the time specified, the Department assesses an additional civil penalty in the amount of $50 for each day that the deficiency continues beyond the date specified for correction.

A facility may, in lieu of contesting a citation, transmit to the Department the minimum amount specified by law for each violation within four business days after the citation has been issued.

If a facility wishes to contest a citation or proposed assessment of civil penalties, it may request an informal "Citation Review Conference" (CRC). The conference is conducted by a hearing officer, employed by the Department. The hearing officer is empowered to affirm, modify or dismiss the citation or proposed assessment of a civil penalty.

Should the facility desire to contest the hearing officer's decision, the facility must inform the Director of the Department of Health, in writing, within four business days after receipt of the decision.

When the Director is notified that a facility intends to contest a citation, he is required to immediately notify the Attorney General. Upon such notification, the Attorney General is required to promptly take all appropriate action to enforce the citation and recover the civil penalty.

Citation enforcement actions are set for trial in Superior Court at the earliest possible date and take precedence on the court calendar over all other cases except matters to which equal or superior precedence is specifically granted by law.

The citation remedies are cumulative and are not construed as restricting any remedy provided by law for the benefit of any party. No judgment shall preclude any party from obtaining additional relief based upon the same facts.

Complaint Investigations

Another important feature of the Long-Term Care, Health, Safety, and Security Act of 1973 is an inspection system to investigate complaints. Any person may request an inspection of a nursing facility by written notification to the Department of Health. When a signed complaint alleging a violation is received, the Department assigns an investigator to evaluate the complaint. If necessary, the Department makes an unannounced on-site inspection of the facility. Written complaints are to be acted upon by the Department within ten working days after receipt of the complaint.

AUDIT RESULTS

INEFFECTIVE SANCTIONS IMPOSED AGAINST SKILLED NURSING FACILITIES

The present system for enforcing quality care in skilled nursing facilities is ineffective. Our review of the citation process disclosed the following:

- Lack of procedures for identifying possible criminal violators
- Need for changes in legislation to impose sanctions against repeat violators
- Lack of enforcement of Class "B" violations in court.

Lack of Procedures for Identifying Possible Criminal Violators

An operator of a skilled nursing facility can be criminally prosecuted for willful or repeated violations of Title 22 of the California Administrative Code. Section 1290 of the Health and Safety Code states:

> Any person who violates any of the provisions of this chapter or who willfully or repeatedly violates any rule or regulation promulgated under this chapter is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not to exceed five hundred dollars ($500) or by imprisonment in the county jail for a period not to exceed 180 days or by both such fine and imprisonment. (Emphasis added.)

A Legislative Counsel Opinion, dated June 23, 1977, concluded:

> . . . the operator of a skilled nursing facility or intermediate care facility may be prosecuted under Section 1290 of the Health and Safety Code for repeated violations of the same regulation prescribing a standard for operation of such facility, even though such violations may have been cited as different classes of violations for purposes of the Long-Term Care, Health, Safety, and Security Act of 1973. (See Appendix A.)

The Department of Health does not maintain a profile or summary of violations of each nursing facility to determine patterns of noncompliance with health and safety standards; yet we have determined that such patterns exist. Since there is no organized system to identify repeat violators, the Department cannot effectively utilize criminal sanctions against facilities which have continually violated the same regulation. Patterns of violations are difficult for the Department to identify because:

- There are approximately 1,200 nursing facilities that must be monitored for compliance at least twice annually

- Numerous citations are issued. For example, 3,283 Class "A" and "B" violations were issued over the 18-month period, October 1975 through March 1977

- The turnover rate of facility inspection team members is approximately 40 percent annually.

During our field review, we analyzed in detail the citations issued to a 122-bed skilled nursing facility. Since summary information is unavailable, we researched inspection, citation and complaint documentation maintained in three different files for this facility. (Files on each facility are from four to eight inches thick and generally contain from about 1,000 to 2,000 pages.) For the 11-month period, March 1976 through January 1977, this facility was cited for violations 134 times. At different times, 21 regulations were cited more than once. The following analysis demonstrates that patterns of violations do exist and illustrates the need for a profile or summary of violations of each nursing facility:

A PROFILE OF ONE FACILITY
SHOWING CODE SECTIONS CITED AND FREQUENCY
(MARCH 1976 THROUGH JANUARY 1977)

Regulation Section*	Type of Violation Cited	Frequency of Section Cited
72315(f)	Nursing care to prevent decubiti, contractures, etc.	5
72547(a)(5)(B)	Content of health records	5
72549(d)	Written report and evaluation of disaster plan	4
72547(a)(5)(F)	Recording of medications and treatment	4
72323(a)	Nursing services staff	4
72667(a)	Storing, handling and transporting linen	3
72311(a)	Identification of problems and plan of care	3
72343(b)	Dietetic services--sanitation of utensils, counters, etc.	3
72313(a)	Medications and treatment as prescribed	3
72661(b)	Procedures for handling linen	2
72343(a)	Dietetic services--sanitation, kitchen area	2
72321(a)(4)	Nursing services--ongoing education program	2
72313(d)	Nursing services--drug administration	2
72387	Activity program and records	2
72617	Patient privacy	2
72633(d)	General maintenance--appropriate personnel	2
72669(c)	Soiled linen	2
72633(b)	General maintenance--buildings and grounds	2
72315(c)	Nursing services--patient orientation	2
72523(a)	Patient rights--written policies	2
72529	Employee name badges	2

*Title 22, California Administrative Code.

While this is an exceptional case, our statewide analysis of repeat Class "A" and "B" violations indicates that 112 facilities were cited for violating the same regulation more than once during an 18-month period. This indicates the need for a system to identify these facilities and patterns of noncompliance so the Department can take appropriate and timely legal action, if necessary.

Need For Changes in Legislation to Impose Sanctions Against Repeat Violators

Current law authorizes the trebling of fines for repeated violations of the same regulation within a 12-month period, but only when civil penalties have been assessed. However, when a Class "B" violation is corrected within the time specified by the facility inspection team, no civil penalty can be imposed against the facility.* The majority of Class "B" violations issued are corrected within the specified time. Therefore, since there is no assessment, penalties for subsequent repeat violations cannot be trebled.

The Legislative Counsel affirmed this position. In an opinion dated June 18, 1977, he stated:

> A Class "B" prior violation which was corrected within the time specified in the citation, so that no civil penalty was imposed, would not be a prior violation for which subdivision (e) of Section 1428 would require a trebling of civil penalties with respect to second or subsequent Class "A" or "B" violations occurring within the 12-month period following the first violation.

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*For Class "A" violations, civil penalties are assessed regardless of when the deficiency is corrected.

Our analysis of the Class "A" and "B" citations issued to skilled nursing facilities statewide disclosed 163 incidents in which the same regulation was cited more than once within a 12-month period. Apparently, the repeated issuance of citations, absent the trebling of fines, did not discourage these facilities from continuing to expose patients to situations that could threaten their health, safety and security.

Lack of Enforcement of Class "B" Violations in Court

When a nursing facility is cited for a violation, the citation is recorded in the Department of Health's files even if the violation has been corrected and no penalty was imposed. To prevent this information from appearing on their records, nursing facilities will often contest the citation.

Current law requires the Department of Health to refer all citations contested by skilled nursing facilities to the Attorney General for enforcement in Superior Court. When a facility disputes a Class "B" violation that has been corrected and has no penalty due, the Attorney General does not enforce the citation in court unless unusual circumstances exist. Once the Attorney General decides not to file an action, the citation is dismissed.

The Attorney General's Office states that nonenforcement of these citations is a reasonable exercise of prosecutional discretion. Since no penalty is due, the Attorney General indicates that the cost

of enforcement to merely affirm the issuance of a citation would unnecessarily increase the burden placed on the Superior Court System.

The Department of Health agrees that it is pointless to ask the Superior Court to use its time and the time of the Attorney General to adjudicate the existence of a violation for which no penalty can be imposed, unless unusual circumstances exist.

The resources of both the State and the skilled nursing industry are inefficiently used when citation enforcement actions are not concluded by prosecution in court. First, the State expends resources to hold Citation Review Conferences. At these conferences, the following state personnel are present:

- The hearing officer
- Members of the facility inspection team
- Special consultants, i.e., physicians, dietitians, as required.

Sometimes an attorney for the State also attends the conference.

Secondly, the State expends resources for the legal review of the contested citation by the Office of Legal Affairs and the Attorney General.

In addition, the nursing facility expends resources to contest the citation. One large nursing facility chain estimates

that expenditures for management and legal fees in a single Citation Review Conference range from $800 to $1,200. These costs do not include travel.

The policy of nonenforcement of contested Class "B" citations encourages facilities to appeal the majority of these citations since nonenforcement is tantamount to dismissal.

The Legislature could consider the following options to correct this situation:

- Class "B" violations repeated within a 12-month period could result in a penalty being automatically imposed regardless of whether the prior violation was corrected
- Fines for Class "B" violations, like Class "A" violations, could be automatically payable even if the violation was corrected within the specified time.

CONCLUSION

The Department of Health has not developed the procedures necessary to identify possible criminal violators. Further, we noted weaknesses in legislation concerning the imposition of civil sanctions against repeat violators and in the enforcement of Class "B" violations in court.

RECOMMENDATIONS

We recommend that the Department of Health maintain a profile or summary of violations of each skilled nursing facility to better detect repeat violators and patterns of noncompliance. The Department should review these profiles for possible criminal or other appropriate legal action.

We recommend that the Legislature consider imposing automatic fines against facilities which repeatedly violate the same regulation regardless of whether the original violation had been corrected within the time specified by the facility inspection team.

We recommend that the Legislature consider the options regarding enforcement of Class "B" violations as listed on page 17 of this report.

BENEFITS

Implementing these recommendations would allow the citation enforcement system to more effectively and efficiently utilize the resources of the State and the skilled nursing industry.

DELAYS IN PREPARING LEGAL ACTIONS AGAINST SKILLED NURSING FACILITIES

The Department of Health and the Office of the Attorney General have not promptly prepared accusations to revoke skilled nursing facility licenses, nor promptly filed civil complaints to enforce citations and collect penalties.

The delays in filing civil complaints and accusations cannot be attributed to any one step in the process, but typically are the result of a series of delays in each of the offices involved, i.e., the Division of Licensing and Certification, the Office of Legal Affairs and the Office of the Attorney General.

Delays in preparing legal actions are partly due to insufficient Attorney General staffing. During our field review, the Attorney General added two attorneys and two stenographers to provide additional support for the licensing and certification effort. The Attorney General also has begun to use paralegal personnel to assist in processing cases. The Attorney General believes that this has reduced the time required to complete legal actions.

The timely prosecution of some cases is delayed by the failure of the Division of Licensing and Certification and the Office of Legal Affairs to properly review the evidence forwarded

to the Attorney General. On numerous occasions the Attorney General has been delayed by the Department of Health's failure to transmit necessary information.

To expedite the prosecution of cases, the Department of Health has assigned attorneys from the Office of Legal Affairs to licensing and certification district offices. The duties of these attorneys include review of legal cases and attendance at Citation Review Conferences.

Accusations Are Not
Promptly Prepared

The Department of Health and the Office of the Attorney General do not promptly prepare accusations leading to license revocation against skilled nursing facilities cited for violating the Health and Safety Code.

The Division of Licensing and Certification may initiate disciplinary actions against nursing facilities to revoke their licenses to operate. The license revocation action is referred to the Office of Legal Affairs in the Department of Health for their review. Following their review, the case is referred to the Attorney General's Public Welfare Section. The Attorney General then prepares an accusation listing the charges against the facility. The charges are prosecuted at a public hearing presided over by an Administrative Law Judge.

By the time a case reaches the Attorney General, it has been judged by both the Division of Licensing and Certification and the Office of Legal Affairs to be of sufficient severity to warrant license revocation action.

We reviewed the 38 cases pending license revocation action that had been referred to the Office of Legal Affairs as of March 28, 1977: 12 facilities continued to operate, 14 facilities were sold, 8 facilities discontinued operations and two revocation actions were discontinued by the Department. Records were incomplete for two other revocation actions.

The median time for the Office of Legal Affairs to review and transmit a license revocation action was 28 days. The median time for the Attorney General to prepare accusations was 92 days.

The total number of days for the Office of Legal Affairs to process and the Attorney General to prepare an accusation ranged from 36 to 652 days. This includes the time expended by both the Attorney General and the Office of Legal Affairs. Appendix B illustrates the number of days spent to prepare these accusations.

The importance of moving swiftly against suspected serious violators cannot be overemphasized. Facilities which continue to operate for an excessive period of time pending license revocation action may pose an unnecessary threat to the health,

safety and security of their patients. Another reason for moving swiftly against suspected serious violators is the possibility that pertinent records and witnesses may not be available because of the passage of time.

Civil Complaints Are Not Promptly Filed

Skilled nursing facilities cited for endangering the health, safety or security of patients have the right to contest the citation. If the facility contests the citation, the Department is required to immediately notify the Attorney General. Upon such notification, the Attorney General is required to take prompt action to enforce the citation and recover civil penalties in Superior Court.

When a facility contests a citation, the Division of Licensing and Certification refers the citation and related evidence to the Office of Legal Affairs which reviews the material and transmits it to the Attorney General.

We reviewed 73 cases pending citation enforcement against skilled nursing facilities as of March 28, 1977:

- The median time for the Division of Licensing and Certification to transmit the citation and related evidence to the Office of Legal Affairs was 32 days

- The median time for the Office of Legal Affairs to review and transmit the contested citation to the Attorney General was 20 days

- The median time for the Attorney General to file the civil action to enforce the citation and recover civil penalties was 62 days.

Appendix C illustrates the number of days taken by each of the offices involved in the citation enforcement.

The Attorney General acknowledges the importance of vigorous citation enforcement in a timely manner. The intent of the Legislature is to establish prompt civil sanctions against violators.

CONCLUSION

The Attorney General and the Department of Health have not promptly prepared accusations to revoke skilled nursing facility licenses nor promptly filed civil complaints to enforce citations and collect penalties. Facilities which continue to operate for excessively long periods pending license revocation action threaten the health, safety and security of their patients. Legislative intent on prompt citation enforcement has not been met.

RECOMMENDATIONS

We recommend that the Division of Licensing and Certification, the Office of Legal Affairs and the Office of the Attorney General develop guidelines and procedures to coordinate their activities and reduce the time to prepare legal actions against skilled nursing facilities.

We recommend that the Department of Health and the Office of the Attorney General report to the Joint Committee on Aging and the Joint Legislative Audit Committee on the effectiveness and efficiency of their new systems for processing legal actions. These reports should be submitted by April 1, 1978.

BENEFITS

Implementing these recommendations would reduce the time required to prepare accusations to revoke nursing facility licenses, and thereby, lessen the threat to the health, safety and security of patients in these facilities.

The prompt preparation of civil complaints to enforce citations and collect civil penalties would meet the legislative intent of the Long-Term Care, Health, Safety, and Security Act of 1973.

INCONSISTENT COMPLAINT PROCEDURES

Citizen complaints are an important source of information on possible violations by nursing facilities. A complaint often may be the first indication to the Department of Health that a facility is not complying with regulations. From our computer analysis we found that one-third of the Class "A" violations resulted from complaint investigations.

Current law mandates that upon the receipt of a written, signed complaint about a nursing facility, the Department of Health is required to make an on-site inspection of that facility within ten working days unless the Department determines the complaint is unreasonable. These complaints are investigated by facility inspectors who are also responsible for full inspections and follow-up visits to nursing facilities.

Complaints are received in district offices by letter, telephone or walk-in visits. The majority are received by telephone. Although the Department's policy is to investigate all complaints, there are no statutory provisions requiring on-site investigations when complaints are received by telephone.

The Department of Health has not developed statewide procedures to manage the complaint investigation process. Each of the licensing and certification district offices has developed its own procedures for prioritizing, investigating and documenting the complaints received.

Each of the district offices that we reviewed used some form of complaint log to record and control the complaints they received. However, the lack of a statewide procedure for complaint control has resulted in inconsistencies in district office documentation. For example, in some district offices:

- The date of the on-site inspection is not indicated
- The disposition of the complaint (whether or not the complaint is substantiated) is not indicated
- Complaint numbers are not assigned
- There is no indication whether the complaint was received in writing or by phone, or whether the complainant is known.

Because of these inconsistencies, it cannot be determined from the complaint log whether statutory requirements are met or whether the investigations are timely. Complaint data, therefore, cannot be effectively used as a management tool for statewide planning and district control.

The confidential complaint files in the district offices also disclosed some deficiencies. In some cases complaints were recorded on the complaint log, but adequate documentation was not in the files. Some complaints in the files had not been recorded on the logs. Documentation was incomplete as to the date received, date investigated, evaluator's findings and observations, conclusions and recommendations.

To obtain complaint summary information, we reviewed individual facility complaint files. Our review of district office complaint records disclosed that there is generally a correlation between facilities having the most complaints and facilities with "A" and "B" citations. However, the Department does not maintain a facility profile or summary of violations including complaint data.

CONCLUSION

Because there is no statewide procedure to control complaint investigations, complaint data cannot be effectively used as a management tool for statewide planning and district control.

RECOMMENDATIONS

We recommend that the Department of Health develop standardized procedures among its district offices for documenting complaints.

We also recommend that the Department of Health include complaint information in a facility profile or summary as recommended on page 18 of this report.

BENEFITS

Implementing these recommendations would provide the Department of Health with a uniform system to control complaint investigations and to provide budgetary planning and management information.

OTHER PERTINENT INFORMATION

A Statewide Rating System For Skilled Nursing Facilities

California does not have a rating system available to the public to provide sufficient information to enable an individual to select a skilled nursing facility on the basis of quality of care.

Current law, however, requires the Department of Health to annually publish a list of facilities without Class "A" or "B" violations for the previous 12 months. Although this system apprises the public of those facilities which have not been found to endanger the health and safety of patients, it is insufficient to provide a basis for quality determination. Appendix D illustrates the distribution of such facilities within each county.

To illustrate the need for a rating system, inspection surveys disclosed that one nursing facility had been cited for 87 deficiencies while another facility had been cited for only 12 deficiencies. The facility with 87 deficiencies also had 19 complaint investigations during calendar year 1976.

Files on skilled nursing facilities are presently maintained at each licensing and certification district office. These records include approximately 1,000 to 2,000 pages of documentation per facility, including inspection surveys, citation notices, complaints and medical review assessments. However, this information is not summarized and cannot be easily provided to interested consumers.

There are several nursing facility rating systems that could be adapted for use in California:

Los Angeles County's Nursing Home Information and Referral Service

The Los Angeles County Board of Supervisors requested the County Department of Health Services to develop a nursing facility information and referral system. This system was implemented in September 1976. The purpose of the system is to match the needs of potential nursing facility patients with available nursing facility services.

This service is available to citizens of Los Angeles County where officials estimate that more than 500 nursing facility referrals are made every month.

Serious patient care violations, as defined by state regulations and county criteria result in an automatic 30-day "do-not-refer" status. A serious patient care violation may

occur if a patient is injured or dies, or if his condition deteriorates under circumstances which indicate that the facilities failed to exercise reasonable surveillance or care. Facility administrators may appeal the decision that places the facility on "do-not-refer" status. Los Angeles County officials indicate that approximately 20 percent of all county facilities are on "do-not-refer" status.

Florida's Nursing Home Rating System

The Florida Legislature has required the promulgation of rules to establish uniform criteria to evaluate nursing facilities regarding their compliance with the minimum standards as indicated by inspection results. Such criteria include a detailed listing of types and degrees of severity of deficiencies, and areas of care and performance in which nursing facilities exceed required minimum standards.

In promulgating such criteria, the health department was required to devise a system of rating nursing facilities on the basis of the quality of care provided. The system selected includes five rating categories. The lowest rating is assigned to nursing facilities whose performance is sufficiently below minimum standards to require suspension, revocation or denial of a license to operate. The rating assigned to each nursing facility is required to be included

in all advertising and conspicuously posted within and without the facility.

This system has not yet been implemented due to court litigation.

The California Legislature may wish to consider requiring implementation of a rating system to provide the public with readily available information to assist in making informed skilled nursing facility selections.

Use of District Attorneys as an Alternative Resource to the Attorney General

The Department of Health could refer cases to district attorneys as an alternative approach to prosecuting charges against skilled nursing facilities. Only the Attorney General is authorized to enforce citations, to collect related penalties and to prosecute administrative revocation actions. However, district attorneys are empowered to prosecute both criminal and civil charges such as prosecution of Section 3369 of the Civil Code for unfair business practices against other facilities.

Until 1975 the Department referred only criminal actions to local prosecutors and all civil litigation was referred to the Attorney General. In October 1976, this policy was modified to permit referral of civil actions to district attorneys.

The advantages of enforcement by district attorneys include:

- Increased local awareness of quality of care issues
- Increased opportunities to expend Attorney General resources in other areas.

We sent questionnaires to all district attorneys asking them to provide the number and type of legal actions they filed against skilled nursing facilities during the last three years. Our survey indicates that only ten cases were filed by district attorneys excluding Los Angeles County.* To our knowledge at least four of these ten cases were initiated by the district attorneys based on available information independent of the Department of Health. The cases include injunctions and civil penalties for unfair business practices and false, misleading or deceptive advertising. Appendix E illustrates the number and type of legal action filed by local prosecutors.

Los Angeles County established a system whereby facility inspectors refer cases to local prosecutors for possible criminal prosecution. The Los Angeles City Attorney has prosecuted 20

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*In Los Angeles County, the L.A. County Department of Health Services performs the licensing and certification function under contract with the State Department of Health.

violators in the past two years in Los Angeles alone compared with only ten prosecutions by district attorneys throughout the rest of the State.

Analysis of Attorney General's Billings to the Department of Health

In fiscal year 1976-77 the Office of the Attorney General provided over 4,000 hours of legal services to the Department of Health for matters relating to skilled nursing facilities. The current billing rate for these services is $37.20 an hour. The services include general services, revocations and civil actions.

An analysis of the Attorney General's billings to the Department of Health for fiscal year 1976-77 shows that three cases represented 38.4 percent of the billings:

	Cost	Percent of Total
General client services	$ 22,200	16.6%
Revocation actions	41,000	30.7
Civil actions	19,000	14.3
Major cases (3 cases described below)	51,100	38.4
Total	$133,300	100.0%

One of the three major cases involved an administrative action to revoke the license of a large skilled nursing facility in San Francisco. The case involved alleged violations of the Health and Safety Code by the facility. After an administrative hearing

the decision was made to revoke the facility's license to operate. The Attorney General's billing for this case was $39,700 in fiscal year 1976-77.

The second major case handled by the Attorney General involved a test case on the constitutionality of the citation enforcement system. A complaint to enforce citations and collect civil penalties was filed in court against a San Diego skilled nursing facility. The facility argued that the citation system violates due process of the law and other constitutional rights of the defendants. The Superior Court judge ruled that the statute under which the cause of action was filed is unconstitutional. The opinion stated:

> . . . the complaint and each cause of action therein fails to state facts sufficient to constitute a cause of action on the ground that the Long-Term Care, Health, Safety, and Security Act of 1973, Health and Safety Code section 1417 et seq., is, by virtue of section 1428(a) thereof being an unconstitutional deprivation of due process, unconstitutional.

The Department of Health has filed an appeal and is seeking a reversal of the judgment. The Attorney General's billing for this case was $5,600 in fiscal year 1976-77.

The third major case involved citation enforcement and collection of civil penalties against a skilled nursing facility in Solano County. This case is still pending in court. The Attorney General's billing for this case was $5,800 in fiscal year 1976-77.

Modified Survey Procedure

Skilled Nursing Facility Survey Reports (Form LIC 822) are completed annually by Department inspection teams for all nursing facilities in accordance with federal and state survey requirements. The survey reports are 91 pages in length and indicate whether standards related to nursing services, medical records, diet, facility plant and administration are being met by nursing facilities. Each violation of the law is additionally documented on a "Statement of Deficiencies and Plan of Correction" (Form SSA 2567).

The Santa Ana Licensing and Certification District Office proposed a pilot project to streamline the facility survey process. All of the information appearing on the 91-page facility survey report was condensed to an 11-page "mark sensing answer sheet." A page from this answer sheet is shown in Appendix F of this report.

Results of the pilot study showed savings in the following areas:

- Reproduction costs (clerical and paper)
- Hours required to write noncompliances in the "Explanatory Statements" column of the survey report
- Hours required to review the surveys

- Storage space

- Elimination of the 91-page facility survey reports.

The Department estimates savings of approximately 23 hours per facility surveyed.

The Santa Ana district office was granted an additional three-month pilot project by the U. S. Department of Health, Education, and Welfare to further explore the potential for using modified survey forms on a statewide basis.

Synopses of the Citation Process

The following information is presented to assist the reader to understand the views of the Department of Health and two large skilled nursing organizations concerning the citation process.

Department of Health

The following are the request to and response of the Department of Health on the criteria used to determine "improvement in levels of care" and "upgrading the quality of services and quality of life," as shown on pages 38 and 39 of this report.

August 25, 1977

Mr. Donald Hauptman
Deputy Director
Licensing and Certification
Department of Health
744 P Street, Room 490
Sacramento, California 95814

Dear Mr. Hauptman:

Pursuant to a request of the Joint Legislative Audit Committee, the Office of the Auditor General was authorized to conduct a review of long-term care for the aged. As a part of our audit, we are reviewing the effectiveness of the Long-Term Care, Health, Safety, and Security Act of 1973 (AB 1600).

Your Division's report to the Legislature titled "The Long-Term Care, Health, Safety, and Security Act of 1973," states on page 1:

> The success of this program has been demonstrated in the improvement of the overall level of care in long-term care facilities throughout the state. . . . The Act has played a critical role in upgrading the quality of services and quality of life for residents confined to long-term care institutions in the State of California.

To assist our review, please provide us with the criteria that you used to identify "improvements in levels of care" and "upgrading the quality of services and quality of life." In addition to the criteria, the data used to reach these conclusions would also be very useful.

We would appreciate your response by September 2, 1977. If you have any questions please contact Mr. Dore C. Tanner at 322-2636.

Sincerely,

John H. Williams
Auditor General

JHW:DCT/arm

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STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY EDMUND G. BROWN JR., Governor

DEPARTMENT OF HEALTH
714-744 P STREET
SACRAMENTO, CALIFORNIA 95814
(916) 445-3281

September 16, 1977

Mr. John H. Williams
Auditor General
California Legislature
925 L Street, Suite 750
Sacramento, CA 95814

Dear Mr. Williams:

This is in response to your letter of August 25, 1977 requesting the criteria we used for our statement that overall levels of care in long-term care facilities had improved, as stated in the Long-Term Care, Health, Safety and Security Act of 1973 report. I am sorry for the delay in reply.

No specific criteria was utilized to make this determination other than the observations and impressions of the Health Facilities evaluator staff.

Our conclusion was based on the effectiveness of the citation process which the Act provided the Department for the enforcement of regulations to assure proper care in these facilities. The Department is now able to penalize a facility immediately for failing to provide acceptable standards of care. Heretofore the only remedy available to the Department was the Administrative Hearing process which often necessitated a lengthy period of time.

The improvement in the quality of care is seen as a result of the enforcement process through the citation system. For example, if a violation of a regulation which constitutes a Class "B" violation, and is subject to a civil penalty of not less than $50 and not exceeding $250, is corrected within the time specified, no civil penalty is imposed. In addition, violations of both Class "A" and Class "B" violations impose a separate civil penalty in the amount of $50 a day if the violation continues beyond the date specified for correction. This has of itself caused facilities to improve by making the necessary corrections in a timely manner in order to avoid the penalty.

I hope this is of assistance to you. If you have any further inquiries please contact me.

Sincerely,

Caroline Cabias for

Don Hauptman, Deputy Director
Licensing and Certification Division

Excerpts from Responses of Two Large
Skilled Nursing Organizations

The Citation Process--A Provider's Point of View by

Beverly Enterprises, Pasadena, California:

"Quality patient care" seems to be the current password that justifies the numerous programs and legislative efforts toward assurance of that result. But are those efforts effective?

Quality assurance methods, whether applied to industrial production or health-care services, must have certain components to be effective. The basic components found in most text books on the subject are:

1) Establishment of standards
2) Documentation of performance
3) Comparison of standards and performance
4) Plan of corrective action and implementing same where significant differences between standards and performance occur
5) Review of performance to evaluate the appropriateness of corrective action.

To analyze the role of the citation system for its contribution to upgrading patient care, we should appraise the system in light of this established quality assurance methodology.

Quality Assurance Components		Citation Components	
Step 1	Establishment of Standard	Step 1	Title 22
Step 2	Documentation of Performance	Step 2	Facility Visits by Surveyors
Step 3	Comparison of Standards and Performances	Step 3	Issuance of Violations
Step 4	Plan of Action	Step 4	Penalty Assessment and Facility's Plan of Correction
Step 5	Review and Assessment of Plan of Action	Step 5	Follow-up Visits by Surveyors

In the opinion of the Provider, the citation system has not satisfied several of the necessary elements of quality assurance methodology. Therefore, it cannot contribute toward improving quality of care as it was intended. As developed in preceding sections, the principal failures are:

Step 1 Differences in interpretation of regulations have clouded the meaning of the established standard.

Step 2 The specific and singular nature of the violation does not adequately represent a documentation of the facility's performance. Such documentation is wholly negative.

Step 3 Variations in the way similar violations are characterized have made comparison of standards and performance totally unreliable; and

Step 4 Diversion of resources from patient care activities has prevented maximum attention to corrective action. The emphasis is increasingly toward "paper compliance" and away from hands-on "patient care."

The concern of the Provider toward the system's noncontributory role is heightened by several other situations which may be totally or partially the result of this system and, if continued, could produce even greater obstacles toward the mutual goal. These situations are:

1) An exodus of professionals from the long-term health-care industry. Good nurses, aides, and administrators will not forever be willing to be involved with totally negative assessments of their performance based upon isolated exceptions, nor will they tolerate criminal prosecutions for circumstances outside of their reasonable control. Many competent administrators, nurses and other professionals have already chosen to leave the field. There is growing evidence that not even escalated wage rates will prevent further migration or stimulate the needed entrance levels of qualified personnel.

2) A widening gap of communication and understanding between the Department of Health and health-care providers.

3) A growing preoccupation with paperwork compliance.

Letter to the Joint Legislative Audit Committee dated August 30, 1977, from Western Medical Enterprises Inc., Hayward, California:

It's been our experience that although some citations are upheld, some are successfully defended, and most should never have been issued. The following costs are estimates based upon our recent experience in defending one citation in a citation hearing:

1. Management Time - Typically, a Regional Vice President, Nurse Consultant, Dietician, Administrator and Director of Nurses will be involved in a citation hearing. In total the hearing will involve five hours of preparation, two hours of research of regulations, five hours to assemble the material, ten hours of travel and ten hours of presentation. In total, this amounts to thirty-two man hours. The direct dollar cost in terms of travel expense, salaries and fringe benefits is estimated at between $400 and $500. Over and above this, however, management talent is a rare commodity which would be better devoted to the care of patients.

2. Direct Legal Expense - A review of our legal bills suggest that we pay attorneys between $400 and $700 to defend a citation. This does not include the attorney's out of pocket cost such as travel and other incidential [sic] costs which might total an additional $100.

3. There is another important cost that you should be aware of. Many talented individuals sorely needed in our industry, such as administrators and nursing directors, have left the industry because of the present inspection and citation process. The fact is that our industry is not able to pay as well as some others. Talented people who are trying to do a good job, unless they are exceptionally devoted as many of our employees are, are not willing to work in our

industry under the present inspection and citation regulations. Typically, it is easy for these people to go to acute facilities or other segments of the health care industry at greater salaries and without the burden presently placed upon this industry by the citation process.

4. It should also be noted that all kinds of fines are levied at various facilities in the process of issuing A and B Citations. Few are even taken to court by the Attorney General. This Corporation has two such actions pending by the Attorney General, one in Ukiah to collect a $250 fine and one in Monterey to collect at [sic] $250 fine. These are the only two actions filed by the State, and this Corporation has received fines totalling well over $100,000 since the law began to be enforced in October, 1975. For your information, our attorneys are convinced that the Attorney General can not win the two pending suits, but it will cost thousands to defend them. Obviously the cost of fines, attorneys and people is re-directed from patient care to this heavy cost area.

Citation Enforcement Information
Requested by the Legislature

To assist us in evaluating the effectiveness of the citation system, we developed a computerized data base of information. The data base included the following information about each skilled nursing facility cited from October 1975 through March 1977:

- District code
- Facility number
- Date of Citation
- Class of Violation

- Type of Visit
- Amount of Penalty Collected
- Regulation Cited
- Number of Counts
- Amount of Penalty Assessment
- Citation Review Conference Hearing Result.

Our information was drawn from citation control sheets maintained by the Department at its district offices. The results of 1,233 surveys of 683 facilities formed the basis for our analysis.

Table 1 on page 46 summarizes by type of inspection the number of regulations cited statewide from October 1975 through March 1977. Over one-third of all Class "A" violations issued during that period were the result of an inspection precipitated by a complaint against a skilled nursing facility. Nearly 75 percent of all Class "B" violations were issued as a result of routine licensing and certification inspections.

Table 2 on page 47 summarizes the Number of Class "A" and "B" violations issued by the eight district offices of the Department of Health.

Table 3 on page 48 summarizes the amount of civil penalties actually collected by each district office. While the amount of collection is small in relation to total assessments,

it should be noted that civil penalties are not collected for Class "B" violations that are corrected within a specified time. In addition, a number of violations were still pending litigation.

Table 4 on page 49 summarizes the results of the Citation Review Conferences held from October 1975 through March 1977. Forty-six percent of the contested Class "A" violations and 31 percent of the contested Class "B" violations were either dismissed or reduced at these conferences.

Table 5 on page 50 shows the number of Class "A" and "B" violations that resulted in a Citation Review Conference. Over 80 percent of all Class "A" violations and 37 percent of all Class "B" violations were contested by skilled nursing facilities.

Table 6 on page 51 shows the number of repeat Class "A" and "B" violations that were issued by each district office. Table 7 on page 52 identifies the counties within each of the eight district offices of the Department of Health.

TABLE I

NUMBER OF CITATIONS ISSUED
AND ORIGINAL ASSESSMENTS
BY TYPE OF INSPECTION
OCTOBER 1975 THROUGH MARCH 1977

	Class "A" Violations			Class "B" Violations		
Type of Visit	Number of Regulations Cited	Original Assessment	Percent of Total Assessment	Number of Regulations Cited	Original Assessment	Percent of Total Assessment
Full Inspection	65	$231,000	36.0%	1,794	$340,750	63.3%
Partial Inspection	12	50,500	7.8	56	11,400	2.1
Follow-up Inspection	12	47,000	7.3	240	44,500	8.3
Complaint Investigation	55	237,000	36.9	421	79,075	14.7
Incident Report(1)	4	11,000	1.7	3	200	-
Other Inspections(2)	16	66,000	10.3	605	62,655	11.6
Totals	164	$642,500	100.0%	3,119	$538,580	100.0%

(1) Incident reports are prepared for unusual occurrences, such as epidemic outbreaks, major accidents, deaths from unnatural causes, etc. These reports are required to be submitted by the facility.

(2) Other inspections include all other types of visits not indicated.

TABLE 2

NUMBER OF CLASS "A" AND CLASS "B"
VIOLATIONS AND ORIGINAL ASSESSMENTS
BY LICENSING AND CERTIFICATION DISTRICT OFFICES
OCTOBER 1975 THROUGH MARCH 1977

	Class "A" Violations			Class "B" Violations		
Districts	Number of Cites	Original Assessment	Percent of Total Assessment	Number of Cites	Original Assessment	Percent of Total Assessment
Berkeley	27	$125,500	19	492	$101,200	18
Fresno	0	0	0	134	52,350	10
Los Angeles	81	303,500	47	1,279	155,475	29
Sacramento	14	77,000	12	234	38,450	7
San Diego	5	14,000	2	134	19,650	4
San Jose	12	49,000	8	403	94,655	18
Santa Ana	12	36,000	6	225	42,450	8
Santa Rosa	13	37,500	6	218	34,350	6
Totals	164	$642,500	100%	3,119	$538,580	100%

TABLE 3

PENALTIES COLLECTED BY
LICENSING AND CERTIFICATION DISTRICT OFFICES
FOR CITATIONS ISSUED
OCTOBER 1975 THROUGH MARCH 1977

	Amount Collected for Violations*		
District	Class "A"	Class "B"	Total
Berkeley	$10,000	$ 1,150	$11,150
Fresno	0	0	0
Los Angeles	11,000	4,500	15,500
Sacramento	0	750	750
San Diego	1,000	0	1,000
San Jose	3,000	2,600	5,600
Santa Ana	7,000	1,800	8,800
Santa Rosa	3,000	200	3,200
Total	$35,000	$11,000	$46,000

*The amounts collected are based upon available information at the time of our review and include some amounts received after March 1977. Class "B" violations corrected by the facility within the time specified by the Department have no penalty due.

TABLE 4

RESULTS OF CITATION REVIEW CONFERENCES
FOR CLASS "A" AND "B" VIOLATIONS
OCTOBER 1975 THROUGH MARCH 1977

	CLASS "A" VIOLATIONS		
	Number of Regulations Cited	Original Assessment	Percent Of Total
Citation Upheld	73	$270,500	52%
Class of Violation and/or Assessment Reduced	36	144,500	28
Date of Correction Changed	2	11,000	2
Citation Dismissed	23	91,000	18
Totals	134	$517,000	100%

	CLASS "B" VIOLATIONS		
	Number of Regulations Cited	Original Assessment	Percent Of Total
Citation Upheld	512	$131,300	66%
Class of Violation and/or Assessment Reduced	304	34,450	17
Date of Correction Changed	25	5,300	3
Citation Dismissed	189	27,150	14
Totals	1,030	$198,200	100%

	TOTAL		
	Number of Regulations Cited	Original Assessment	Percent Of Total
Citation Upheld	585	$401,800	56%
Class of Violation and/or Assessment Reduced	340	178,950	25
Date of Correction Changed	27	16,300	2
Citation Dismissed	212	118,150	17
Totals	1,164	$715,200	100%

TABLE 5

CITATION REVIEW CONFERENCES
REQUESTED/NOT REQUESTED BY FACILITIES
OCTOBER 1975 THROUGH MARCH 1977

	CLASS "A" VIOLATIONS		
	Number of Regulations Cited	Original Assessment	Percent Of Total
Citation Review Conferences Requested by Facilities	134	$517,000	80%
Citation Review Conferences Not Requested	30	125,500	20
Totals	164	$642,500	100%

	CLASS "B" VIOLATIONS		
	Number of Regulations Cited	Original Assessment	Percent Of Total
Citation Review Conferences Requested by Facilities	1,030	$198,200	37%
Citation Review Conferences Not Requested	2,089	340,380	63
Totals	3,119	$538,580	100%

	TOTAL		
	Number of Regulations Cited	Original Assessment	Percent Of Total
Citation Review Conferences Requested by Facilities	1,164	$ 715,200	61%
Citation Review Conferences Not Requested	2,119	465,880	39
Totals	3,283	$1,181,080	100%

TABLE 6

SUMMARY OF REPEAT
CLASS "A" AND "B" VIOLATIONS
OCTOBER 1975 THROUGH MARCH 1977

District	Incidents In Which the Same Regulation Was Cited Repeatedly		
	Within 12 Months	Over 12 Months	Total
Berkeley	28	0	28
Fresno	10	1	11
Los Angeles	75	5	80
Sacramento	10	0	10
San Diego	2	0	2
San Jose	19	0	19
Santa Ana	11	0	11
Santa Rosa	8	1	9
Total	163	7	170

TABLE 7

DIVISION OF LICENSING AND CERTIFICATION
COUNTIES BY DISTRICT OFFICES

Berkeley

Alameda
Contra Costa
Marin
San Francisco
San Mateo

Fresno

Fresno
Kern
Kings
Madera
Mariposa
Tulare

Los Angeles

Los Angeles

Sacramento

Alpine
Amador
Butte
Calaveras
Colusa
El Dorado
Glenn
Lassen
Merced
Modoc
Nevada
Placer
Plumas
Sacramento
San Joaquin
Shasta
Sierra
Siskiyou
Stanislaus
Sutter
Tehama
Trinity
Tuolumne
Yolo
Yuba

San Diego

Imperial
San Diego

San Jose

Monterey
San Benito
San Luis Obispo
Santa Barbara
Santa Clara
Santa Cruz
Ventura

Santa Ana

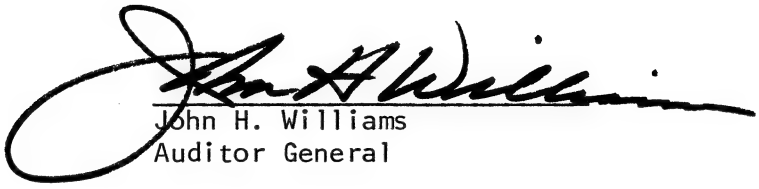
Inyo
Mono
Orange
Riverside
San Bernardino

Santa Rosa

Del Norte
Humboldt
Lake
Mendocino
Napa
Solano
Sonoma

Our data base of citation information is available for further analysis by the Legislature or the Department of Health if desired.

Respectfully submitted,



John H. Williams
Auditor General

September 30, 1977

Staff: Harold L. Turner
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Kathleen A. Herdell

DEPARTMENT OF HEALTH
714 P STREET
SACRAMENTO, CALIFORNIA 95814

September 30, 1977

Mr. John H. Williams
Auditor General
Joint Legislative Audit Committee
925 L Street, Suite 750
Sacramento, CA 95814

Re: Draft Report No. 275.2

Dear Mr. Williams:

The Department would like to make the following comments on areas mentioned in the report:

1. Procedural Changes

   a. The Department has drafted and is currently reviewing a Health Care Manual for all health evaluators that standardizes policies, procedures, and forms for: 1) logging, investigating, and documenting all complaints received, and 2) documenting and processing legal actions. Along with training for field staff, this uniformity will enable a more efficient processing of legal actions.

   b. A uniform case identification process has been established in conjunction with the Attorney General's Office.

   c. Facility requests for review of citations in Superior Court are now being sent directly from the district licensing offices to the Attorney General's Office, with simultaneous copies to the Office of Legal Affairs and the licensing headquarters office. This will prevent any possibility of internal departmental delay in citation referrals.

   d. Requests for license revocation are now being directly sent to the Office of Legal Affairs and the licensing headquarters office on a simultaneous basis from the licensing district office. This will eliminate a possible source of delay in revocation referrals.

2. Delays and Staffing

During the period covered by the report, the Department's Office of Legal Affairs suffered a severe staff shortage in the licensing area. A total of only 2.5 man-years was available for assignment to this area. In addition to the license revocation and citation enforcement actions discussed in the report, these attorneys were responsible for handling all legal matters for the Licensing and Certification Division, including legal opinions from the headquarters and district offices, legal review of regulations, legal review of proposed and pending legislation, and contract negotiations for the Division, as well as all legal problems generated by the Facilities Construction Section of the Division (the Hill-Burton Program, the Cal Mortgage Loan Insurance Program, and the Continuing Care Facilities Program).

Recognizing the staffing problems, the Department has attempted to temporarily redirect attorneys from other workload areas to assist the Licensing and Certification Division. In May, three attorneys were temporarily assigned to this area, and in August, an additional two attorneys were temporarily added. These five attorneys are now available to assist five of the district offices with the processing of revocation actions and enforcement citations on a local level. However, unless additional permanent positions are obtained, this temporary re-direction will have to cease because of the legal workload in the areas from which the attorneys were diverted.

3. Facility Profile

The Department currently obtains data on Form FIS 010 on complaints logged and substantiated during a twelve month period. This form will be modified to collect data on violations cited in order to identify repeated violations for possible court action.

4. Criminal Referrals

The Department believes that proper referral for criminal prosecution can only be achieved through effective coordination with the local prosecutor's office. To this end, the Department, in conjunction with the Los Angeles City Attorney's Office and District Attorney's Office, has developed guidelines for referral of matters for criminal prosecution. The Department is also meeting with the Consumer Council of the California District Attorney's Association in an attempt to develop similar guidelines for use on a statewide basis.

5. Conflicting Priorities

A significant problem not addressed by the Report is the problem in setting priorities for staff activities based on federal regulation requirements versus state statute requirements with conflicting timetables. The Department is currently working with HEW to resolve the problem of overlapping priority survey schedules and complaint followups which hinder effective enforcement/licensing activities.

6. Legislative Action

The Department concurs in the Auditor General's recommendation that the Legislature amend the Long Term Care Health and Safety and Security Act of 1973 to impose an automatic fine for repeated violations (regardless of whether the earlier violation was corrected) and/or to impose fines for all "B" citations, whether corrected or not. In April of this year, the Department of Health sponsored AB 1644, introduced by Assemblyman Agnos, which would go far to accomplish the Auditor General's recommendation in this regard.

Sincerely,

Tom Elkin for

Jerome A. Lackner, M.D.
Director of Health

EVELLE J. YOUNGER
ATTORNEY GENERAL

STATE OF CALIFORNIA

OFFICE OF THE ATTORNEY GENERAL
Department of Justice
STATE BUILDING, SAN FRANCISCO 94102
(415) 557-2544

September 29, 1977

John H. Williams
Auditor General
Joint Legislative Audit Committee
California Legislature
Suite 750
925 L Street
Sacramento, CA 95814

Re: Draft Report No. 275.2

We would make the following comments on your draft report entitled "Department of Health Deficiencies in Monitoring and Enforcing Quality of Care to Nursing Home Patients" as it pertains to the Office of the Attorney General. Before doing so, however, we would like to express our recognition of the thoroughly professional manner in which your staff conducted its investigation. We would also like to express our appreciation for the courtesies extended by your staff in adjusting their schedules to meet the heavy litigation schedules of the deputies whose files were being reviewed.

The report states that the median time for this office to prepare and file actions was 62 days in the case of citations and 92 days in the case of accusations. The report concludes that this office did not act "promptly." It is not necessary for us to quarrel with the validity of those figures. Nor is it necessary to argue about whether such actions were not "prompt", given the conditions and restraints under which we had to work. As noted in the report, these "delays in preparing legal actions are partly due to insufficient Attorney General staffing." The lack of sufficient staff was not a problem which this office could unilaterally correct. The handling of nursing home matters for the Department of Health was, and still is, a special fund activity of this office. When our request for more

staff for these purposes was approved by the Department of Health and the Department of Finance, additional positions were added and filled. The addition of these new positions enabled us to initiate a new procedure for the preparation and filing of accusations and citation actions.

A preliminary review indicates that the new system with additional staff has produced a dramatic reduction in the time taken by this office for the preparation and filing of accusations and citation enforcement actions. From July 1, 1977 to September 15, 1977, the Department of Health referred 32 such matters to this office. Our records show that the time from receipt of the case until completion of the complaint or accusation in form for filing, excluding days during which the matter was referred back to the department for additional documentation, was on the average 6.25 working days. After the document is prepared for filing, it is referred to a Deputy Attorney General in the appropriate regional office for review and filing. This has taken, on the average, an additional 8.2 working days. Thus, when we are given adequate documentation, cases are being filed in less than 3 calendar weeks from the date the matter is referred to this office. We are working to reduce this even further. We are confident that if your staff reviewed the situation as it actually exists today, you would conclude that this office does indeed act "promptly" on these matters.

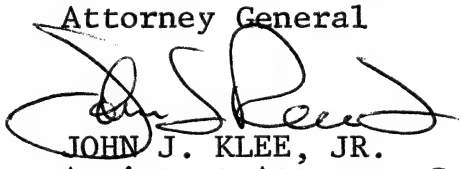
There is one facet of the matter which is not covered by the report but which probably should be considered by the Legislature if the entire question of "prompt and effective" enforcement actions is to be dealt with, namely, the fact that there are long delays in getting the matters heard by an administrative law judge or the Superior Court. Once an accusation is filed, it normally takes several months before the matter can be heard by the Office of Administrative Hearings. If a decision revoking the license is eventually rendered, the nursing home operator can seek judicial review pursuant to Code of Civil Procedure section 1094.5. It is

the normal practice of superior courts to stay the administrative decision pending judicial review. As a result, several months, or perhaps years, go by after the accusation is filed during which time the nursing home is allowed to operate. In the case of citation enforcement actions, we are encountering the same sort of delays. Attorneys for the nursing home operators have initiated broad discovery procedures and most of the superior courts are not setting the cases for trial at an early date.

These latter delays, of course, cannot be corrected by this office or the Department of Health. This office would, however, be happy to work with your office or the Legislature to explore potential corrective legislation.

Very truly yours,

EVELLE J. YOUNGER
Attorney General



JOHN J. KLEE, JR.
Assistant Attorney General

JJK:my

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Sacramento, California
June 23, 1977

Honorable Mike Cullen
Assembly Chamber

Long-Term Health Care Facilities - #9131

Dear Mr. Cullen:

You have asked two questions concerning long-term health care facilities, which are separately stated and considered below.

QUESTION NO. 1

May the operator of a skilled nursing facility or intermediate care facility be prosecuted under Section 1290 of the Health and Safety Code for repeated violations of the same regulation prescribing a standard for operation of such a facility if the violations have been cited or noticed as different classes of violations for purposes of the Long-Term Care, Health, Safety, and Security Act of 1973?[1]

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[1] The Long-Term Care Health, Safety, and Security Act of 1973 (Ch. 2.4 (commencing with Sec. 1417), Div. 2, H.& S.C.), as discussed in Analysis No. 1, requires the State Department of Health to classify violations according to the degree of danger presented to the health or safety of patients (Secs. 1423, 1424, 1426, and 1427, H.& S.C.).

OPINION NO. 1

The operator of a skilled nursing facility or intermediate care facility may be prosecuted under Section 1290 of the Health and Safety Code for repeated violations of the same regulation prescribing a standard for operation of such facility, even though such violations may have been cited as different classes of violations for purposes of the Long-Term Care, Health, Safety, and Security Act of 1973.

ANALYSIS NO. 1

Chapter 2 (commencing with Section 1250) of the Health and Safety Code[2] provides for licensure of health facilities, including skilled nursing facilities and intermediate care facilities (see Sec. 1250), by the State Department of Health (Secs. 1253 and 1254). Under the provisions of Chapter 2, the department is required to adopt regulations prescribing standards of adequacy, safety, and sanitation of the physical plant of health facilities and prescribing standards for staffing and services (Secs. 1275 and 1276). Section 1290 specifies criminal penalties for willful or repeated violation of any regulation adopted pursuant to Chapter 2, as follows:

> "1290. Any person who violates any of the provisions of this chapter or who willfully or repeatedly violates any rule or regulation promulgated under this chapter is guilty of a misdemeanor and upon conviction thereof shall be punished by a fine not to exceed five hundred dollars ($500) or by imprisonment in the county jail for a period not to exceed 180 days or by both such fine and imprisonment."

As contrasted with criminal penalty provisions of Section 1290, the Long-Term Care, Health, Safety, and Security Act of 1973 (see footnote 1) provides for a scheme of citations (or notices) and civil penalties for violations of statutory provisions or administrative rules and regulations pertaining to the operation or maintenance of long-term health care facilities (Sec. 1423), which are defined to include skilled nursing facilities and intermediate care facilities (subd. (a), Sec. 1418). Many of the regulations

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[2] All section references are to the Health and Safety Code.

adopted by the State Department of Health under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code are, therefore, subject to the enforcement procedures of the Long-Term Care, Health, Safety, and Security Act of 1973.

However, the remedies provided under such act are not exclusive (Sec. 1433). Therefore, violation of a regulation adopted pursuant to the health-facility licensing provisions of Chapter 2 could be both punishable as a criminal offense under Section 1290, if the violation were willful or repeated, and also be subject to a civil penalty under the Long-Term Care, Health, Safety, and Security Act of 1973.

For purposes of such act, violations are classified according to severity. Class "A" violations are violations which the State Department of Health determines present an imminent danger to the patients or guests of a long-term health care facility or a substantial probability that death or serious physical harm would result therefrom (subd. (a), Sec. 1424). Class "B" violations are violations determined by the department to have a direct or immediate relationship to the health, safety, or security of patients of a long-term health care facility, other than Class "A" violations (subd. (b), Sec. 1424). Other violations (Class "C" violations; see Sec. 72709, Title 22, Cal. Adm. C.) subject to the act are those determined by the department to have only a minimal relationship to safety or health (subd. (b), Sec. 1424).

Conceivably, violation of any particular regulation could fall within any one of the above three classifications, depending upon the degree of the threat to health or safety posed by the violation. However, the application of the criminal provisions of Section 1290 is not dependent upon how a particular violation is classified for purposes of the Long-Term Care, Health, Safety, and Security Act of 1973. Section 1290 is applicable to willful or repeated violations, and the severity of the particular violation is not a factor in the application of Section 1290.

Thus, we conclude that the operator of a skilled nursing facility or intermediate care facility may be prosecuted under Section 1290 of the Health and Safety Code for repeated violations of the same regulation prescribing a standard for operation of such facility, even though such violations may have been cited as different classes of violations for purposes of the Long-Term Care, Health, Safety, and Security Act of 1973.

QUESTION NO. 2

May the State Department of Health assess the civil penalty prescribed by Section 1425 of the Health and Safety Code where the licensee of a long-term health care facility has partially but not fully corrected the condition constituting the cited violation within the time specified in the citation?

OPINION NO. 2

The State Department of Health must assess the civil penalty prescribed by Section 1425 of the Health and Safety Code where the licensee of a long-term health care facility has partially but not fully corrected the condition constituting the cited violation within the time specified in the citation.

ANALYSIS NO. 2

Section 1425 reads as follows:

> "1425. Where a licensee has failed to correct a violation within the time specified in the citation, the state department shall assess the licensee a civil penalty in the amount of fifty dollars ($50) for each day that such deficiency continues beyond the date specified for correction."

This section requires the state department to assess licensees for each day that the deficiency continues beyond the date specified for correction (see Sec. 16).

Neither Section 1425 nor any other provision of the Long-Term Care, Health, Safety, and Security Act of 1973 permits or requires waiver of the civil penalty specified in Section 1425 where a violation has only been partially corrected within the time specified in the citation.

Thus, we conclude that the State Department of Health must assess the civil penalty prescribed by Section 1425 of the Health and Safety Code where the licensee of a long-term health care facility has partially but not fully corrected the condition constituting the cited violation within the time specified in the citation.

Very truly yours,

Bion M. Gregory
Legislative Counsel

By
Peter Melnicoe
Deputy Legislative Counsel

PM:mcj

THE TOTAL NUMBER OF DAYS FOR THE OFFICE OF LEGAL AFFAIRS TO PROCESS AND THE ATTORNEY GENERAL TO PREPARE AN ACCUSATION TO REVOKE A FACILITY LICENSE

	Completed Accusations		Incompleted Accusations	
Number of Days	Facilities Operating	Facilities Sold or Closed	Facilities Operating	Facilities Sold or Closed
1- 20				
21- 40		1		
41- 60		2		
61- 80	1	2		
81-100	3	2		
101-120	1			
121-140	1			
141-160	1	1		
161-180		1	1	
181-200			1	2
201-250	2	2		
251-300		2		1
301-350	1	3		
Over 351 days	—	2	—	1
Totals	10	18	2	4

Note: Of the 38 cases pending license revocation action, two cases were discontinued and records were incomplete for two facilities.

THE NUMBER OF DAYS SPENT ON CONTESTED CITATIONS BY THE OFFICES INVOLVED IN CITATION ENFORCEMENT

	Number of Contested Citations		
	Department of Health		
Number of Days	Division of Licensing and Certification (1)	Office of Legal Affairs (2)	Office of the Attorney General (3)
1- 20	26	35	0
21- 40	20	18	6
41- 60	13	7	1
61- 80	3	1	7
81-100	4	1	1
101-120	2	0	0
121-140	0	2	1
141-160	1	0	0
Over 161 days	0	0	1

(1) Time spent by the Division of Licensing and Certification to transmit contested citations to the Office of Legal Affairs.

(2) Time spent by the Office of Legal Affairs to review and transmit contested citations to the Office of the Attorney General.

(3) Time spent by the Office of the Attorney General to file civil complaints to enforce the citations and collect penalties.

NUMBER OF FACILITIES WITHOUT CLASS "A" OR "B" VIOLATIONS BY COUNTY FOR CALENDAR YEAR 1976

County	Number of Facilities	County	Number of Facilities
Alameda	55	Orange	47
Alpine	-	Placer	4
Amador	2	Plumas	3
Butte	9	Riverside	22
Calaveras	1	Sacramento	31
Colusa	2	San Benito	2
Contra Costa	22	San Bernardino	33
Del Norte	1	San Diego	46
El Dorado	1	San Francisco	14
Fresno	23	San Joaquin	13
Glenn	1	San Luis Obispo	2
Humboldt	4	San Mateo	20
Imperial	3	Santa Barbara	11
Inyo	2	Santa Clara	37
Kern	4	Santa Cruz	10
Kings	1	Shasta	2
Lake	-	Sierra	-
Lassen	2	Siskiyou	-
Los Angeles	192	Solano	5
Madera	2	Sonoma	3
Marin	10	Stanislaus	15
Mariposa	-	Sutter	2
Mendocino	2	Tehama	2
Merced	6	Trinity	-
Modoc	2	Tulare	5
Mono	-	Tuolumne	1
Monterey	11	Ventura	13
Napa	3	Yolo	6
Nevada	3	Yuba	1

	Number of Counties	Number of Facilities
Totals	58	714

APPENIDX E

NUMBER AND TYPES OF LEGAL ACTIONS
FILED BY LOCAL PROSECUTORS

County	Number of Actions	Description of Legal Actions
Alameda	None	
Amador	None	
Butte	None	
Colusa	None	
Contra Costa	1	-Injunction, civil penalties and other relief--unfair business practices
El Dorado	None	
Fresno	1	-Grand Theft
Glenn	None	
Imperial	None	
Inyo	None	
Kern	None	
Kings	None	
Lake	None	
Lassen	None	
Los Angeles (City Attorney)	20	-Not clean, safe and sanitary conditions -Not clean, safe and sanitary conditions -Not clean, safe and sanitary conditions -Inadequate conditions and procedures -Not clean, safe and sanitary conditions -Not clean, safe and sanitary conditions -Commingling patient funds -Patient care violation and injunction -Civil injunction not to interfere with inspection -Insanitary conditions, improper drug--trial pending -Unclean conditions, insanitary laundry handling procedures -Commingling of patient funds -Unlawful disposing of pathological specimens -Assault and battery on patient--dismissed -Aiding and abetting assault and battery -Diverting drugs for own use -Practicing as registered nurses in hospital and two nursing homes -Patient assault -Practicing as nurse without license -Practicing as nurse without license
Madera	None	
Marin	None	
Mariposa	None	
Mendocino	None	
Modoc	None	
Mono	None	
Monterey	1	-Injunction, civil penalties and criminal complaint--unfair business practices
Napa	1	-Injunction, civil penalties and other relief--unfair business practices
Nevada	None	
Placer	None	
Riverside	None	
Sacramento	1	-Practicing medicine without a license
San Benito	None	
San Bernardino	None	
San Diego	2	-Civil penalties and injunction -Civil penalties and injunction
San Francisco	1	-Injunction, civil penalties and other relief--unfair business practices
San Luis Obispo	None	
San Mateo	None	
Santa Barbara	None	
Santa Clara	1	-Injunction, civil penalties and other relief--unfair business practices
Santa Cruz	1	-Fraudulent claims
Shasta	None	
Sierra	None	
Siskiyou	None	
Solano	None	
Sonoma	None	
Stanislaus	None	
Sutter	None	
Tehama	None	
Trinity	None	
Tulare	None	
Tuolumne	None	
Ventura	None	

NOTE: Ten counties did not or were unable to respond to our questionnaire on civil, criminal or other filings in the last three years.

STATE OF CALIFORNIA NURSING FACILITY SURVEY REPORT	F1 Provider Number (Title XVIII)	F2 Vendor Number (Title XIX)

Name of Facility	Street Address	City	County	State	Zip Code

F3 Surveyed by	Surveyor's Professional Title	F4 (1) ☐ Initial Survey (2) ☐ Re-Survey	F5 Date Surveyed

F6
List Additional Surveyors' Names and Title

KEY: Y= yes N= no NA= not applicable M= met NM= not met

	M	NM
F7	"	"
F8	"	"
	Y	N
72201	"	"
72221	"	"
F9	_____	
F10	_____	
F11	_____	
F12	_____	
F13	M "	NM "
F14	"	"
	Y	N
72203	"	"
72241(a)	"	"
(b)	"	"
(c)	"	"
	$_____	
	$_____	
	$_____	

	Y	N	NA
72301(a)	"	"	
(c)	"	"	"
72307	"	"	
72311(d)	"	"	
72315(b)	"	"	
(c)	"	"	
72325(a)(1)	"	"	
(a)(2)	"	"	
(a)(3)	"	"	
(a)(4)	"	"	
(a)(5)	"	"	
72337 (e)	"	"	
(g)	"	"	
72341(d)	"	"	
72343(d)	"	"	
72345(a)	"	"	
(b)	"	"	
(c)	"	"	
(d)	"	"	
(e)	"	"	
72347(d)	"	"	
(e)(1)	"	"	
72349(b)(1)	"	"	
(b)(2)	"	"	
(b)(3)	"	"	
(b)(4)	"	"	
(b)(5)	"	"	
(b)(6)	"	"	"
	"	"	"
	"	"	"
	"	"	"

	Y	N	NA
72647(e)	"	"	"
72351(b)	"	"	"
72359	"	"	
72363	"	"	
72369(j)	"	"	
(k)	"	"	"
72373(c)(1)	"	"	"
(2)	"	"	"
(3)	"	"	"
72375	"	"	"
	"	"	"
	"	"	"
72379(a)(1)	"	"	"
(a)(2)	"	"	"
(a)(3)	"	"	
(a)(4)	"	"	
(a)(5)	"	"	
(a)(6)	"	"	
72387	"	"	"
72501(a)	"	"	
(d)	"	"	
(f)	"	"	

	Y	N	NA
72502(a)	"	"	
(a)(1)	"	"	
(a)(2)	"	"	
(a)(3)	"	"	
(a)(4)	"	"	
(a)(5)	"	"	"
(a)(6)	"	"	"
(a)(7)	"	"	"
72507	"	"	
72509(a)	"	"	"
(b)	"	"	"
(c)	"	"	
(d)	"	"	
72513	"	"	
72515	"	"	
72517(b)	"	"	
(c)	"	"	
72519(a)(3)	"	"	
(a)(4)	"	"	
72533	"	"	"
72535	"	"	"
72537	"	"	"
72539	"	"	"
72541	"	"	

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
California State Department Heads
Capitol Press Corps